## Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

Metformin Glucophage   Metformin Glucophage   Metformin Glucophage   Metformin (Extended Release)   Metformin (Extended Rele		O	-	O	
Physician signature   Date	Please do so in the spa	prescribe a Preferred Drug, ace provided and	<b>tx</b>		
Preferred This includes all generic equivalents Drug Covered  Metformin Glucophage® Metformin (Extended Release) This includes all generic equivalents Prior Authorization Required  ** Indicates REQUIRED information  **CONSUMER NAME: **Medicaid Number: **Medicaid Number: **PHARMACY NAME: **Fax Number: **NDC: **PRESCRIBING PHYSICIAN NAME: **Fax Number: **Medicaid Number: **Phone Number: **Fax Number: **Phone Number: **Fax Number: **Medicaid Number: **Phone Number: **Fax Number: **Medicaid Number: **Phone Number: **Phone Number: **Fax Number: **Medicaid Number: **Phone Number: **Phone Number: **This includes all generic equivalents Prior Authorization Required  Metformin (Extended Glucophage XR® Fortamet®  **Medicaid Number: **Medicaid Number: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Medicaid Number: **Prior Authorization Number: **Medicaid Number: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: ***Medicaid Number: ****Medicaid Number: ***Medicaid Number: ***	process by completing FAX completed form	g the rest of this form & to the Prior Authorization Unit	Physician signature	e Date	
Preferred This includes all generic equivalents Drug Covered  Metformin Glucophage® Metformin (Extended Release) This includes all generic equivalents Prior Authorization Required  ** Indicates REQUIRED information  **CONSUMER NAME: **Medicaid Number: **Medicaid Number: **PHARMACY NAME: **Fax Number: **NDC: **PRESCRIBING PHYSICIAN NAME: **Fax Number: **Medicaid Number: **Phone Number: **Fax Number: **Phone Number: **Fax Number: **Medicaid Number: **Phone Number: **Fax Number: **Medicaid Number: **Phone Number: **Phone Number: **Fax Number: **Medicaid Number: **Phone Number: **Phone Number: **This includes all generic equivalents Prior Authorization Required  Metformin (Extended Glucophage XR® Fortamet®  **Medicaid Number: **Medicaid Number: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Medicaid Number: **Prior Authorization Number: **Medicaid Number: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Medicaid Number: **PRESCRIBING PHYSICIAN NAME: **Medicaid Number: ***Medicaid Number: ****Medicaid Number: ***Medicaid Number: ***		This is also do a all			
Preferred This includes all generic equivalents Drug Covered  Metformin Glucophage*  ** Indicates REQUIRED information  ***CONSUMER NAME:				<u> </u>	
Metformin Glucophage®  Metformin (Extended Glucophage XR® Release)  ** Indicates REQUIRED information  **CONSUMER NAME:  **PHARMACY NAME:  **Phone Number:  **Phone Number:  **Phone Number:  **PRESCRIBING PHYSICIAN NAME:  **Phone Number:  **Prescribed:  **Phone Number:  **Prescribed:  **Preferred Drug prescribed:  **Dother:  **  **Indicate: Non-Preferred Drug and provide the requested information:  Medical intolerance to Preferred Drug.  **  Inadequate response to Preferred Drug.  **  Indicate: Preferred Drug tried:  Absence of appropriate formulation or indication of the drug. Please specify:  Absence of appropriate formulation or indication of the drug. Please specify:	Preferred				
** Indicates REQUIRED information  **CONSUMER NAME:	Drug Covered	rug Covered		Prior Authorization Required	
** Indicates REQUIRED information  **CONSUMER NAME:	Metformin	Glucophage <sup>®</sup>	Metformin (Extende	ed Glucophage XR®	
**Phone Number:	**CONSUMER NAME:				
**PRESCRIBING PHYSICIAN NAME: **Medicaid Number: **Phone Number: **Fax Number: **Fax Number: Other: **  *** **Indicate**: Non-Preferred Drug prescribed: Other: **  *** **Check**: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:					
**Phone Number: **Fax Number: Other:    ** Indicate: Non-Preferred Drug prescribed: Other:    ** Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:    Medical intolerance to Preferred Drug. Provide clinical symptoms:    Inadequate response to Preferred Drug.    ** Indicate: Preferred Drug tried: Length of trial:    Absence of appropriate formulation or indication of the drug. Please specify:					
** Indicate: Non-Preferred Drug prescribed:Other:  ** Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:  Medical intolerance to Preferred Drug. Provide clinical symptoms:					
** Check: the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:  Medical intolerance to Preferred Drug. Provide clinical symptoms:  Inadequate response to Preferred Drug.  ** Indicate: Preferred Drug tried:  Absence of appropriate formulation or indication of the drug. Please specify:				Other:	
Inadequate response to Preferred Drug.  ** Indicate: Preferred Drug tried: Length of trial:  Absence of appropriate formulation or indication of the drug. Please specify:	** <i>Check:</i> the app	propriate box indicating medical neces			
** Indicate: Preferred Drug tried: Length of trial: Absence of appropriate formulation or indication of the drug. Please specify:	Medical intole	erance to Preferred Drug. Provide cli	inical symptoms:		
Absence of appropriate formulation or indication of the drug. Please specify:	Inadequate re	sponse to Preferred Drug.			
Absence of appropriate formulation or indication of the drug. Please specify:	— ** Indicate	: Preferred Drug tried:	1	Length of trial:	
**Dragoribing Dhygigian's signature:					
	**Dragarihina Dhysisi	on's signature:		Date:	

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka. General support is provided at 800-933-6593.

Revised 03/19/06